



January 8, 2018

VIA EMAIL AND HAND-DELIVERY

Kevin McDonald, Chief  
Maryland Health Care Commission  
Center for Health Care Facilities  
Planning & Development  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Re: In the Matter of Visiting Nurse Association of Maryland's CON Application to  
Expand a Home Health Agency in the Lower Eastern Shore  
Docket No. 17-R4-2407

Dear Mr. McDonald:

Please find enclosed an original and six (6) copies of the Interested Party written comments of our client, Peninsula Home Care, LLC, to be filed in the above-referenced matter. Please also find enclosed two separate requests, one for the opportunity to present oral argument before a proposed decision is prepared and a second for an evidentiary hearing. Thank you for your attention to this matter. We would be pleased to answer any questions that you may have regarding these comments.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Peter P. Parvis'.

Peter P. Parvis  
Molly E. G. Ferraioli  
Attorneys for Peninsula Home Care, LLC

Enclosures

cc: Mariama Gondo  
William Chan  
Ruby Potter  
Suellen Wideman, Esq.  
Todd Wiebusch  
Nancy Bagwell  
Jennifer Kline  
Rich Coughlan  
Barry M. Ray, VNA CEO  
J. Craig Stofko, Health Officer for Somerset County  
Lori A. Brewster, Health Officer for Wicomico County  
Rebecca L. Jones, R.N., Health Officer for Worcester County  
Roger L. Harrell, Health Officer for Dorchester County

IN THE MATTER OF	*	BEFORE THE
VISITING NURSE ASSOCIATION OF	*	MARYLAND HEALTH
MARYLAND, LLC	*	CARE COMMISSION
CON APPLICATION TO EXPAND A	*	Docket No. 17-R4-2407 <sup>1</sup>
HOME HEALTH AGENCY IN THE		
LOWER EASTERN SHORE	*	

\* \* \* \* \*

**INTERESTED PARTY COMMENTS OF PENINSULA HOME CARE, LLC**

**I. INTRODUCTION**

Peninsula Home Care (“PHC”) submits these written comments (“Comments”) pursuant to section 10.24.01.08F(1) of the Code of Maryland Regulations (“COMAR”) as an “interested party” in the review of the Certificate of Need (“CON”) application (the “Application”) submitted by Visiting Nurse Association of Maryland, LLC (“VNA” or the “Applicant”) to expand its services to residents of the Lower Eastern Shore region of Maryland: Dorchester, Wicomico, Somerset and Worcester Counties. VNA’s proposal would add a sixth home health agency<sup>2</sup> to this distinctively rural and economically-challenged region that VNA does not currently serve and has submitted no credible evidence that it is prepared to serve.

There is no need for an additional home health agency to serve residents of this geographic region. VNA’s application advances internal corporate goals only, through a plan to capture referrals and treat residents who PHC and multiple other home health agencies currently serve. This internal business goal of expanding VNA’s geography indicates no understanding of

---

<sup>1</sup> VNA’s responses to the Completeness Questions lists the docket number as 17-R2-2407.  
<sup>2</sup> The following five home health agencies are authorized to serve residents of the Lower Eastern Shore: Dorchester County: Home Call, Amedisys Home Health Care, and Shore Home Care; Somerset County: PHC, Amedisys Home Health Care, and Encompass Home Health of Maryland (formerly HealthSouth Chesapeake); Wicomico County: PHC, Home Call, Encompass Home Health of Maryland, and Amedisys Home Health Care; and Worcester County: PHC, Amedisys Home Health Care, Home Call and Encompass Home Health of Maryland.

the service needs of these residents, the uniqueness of the area, the track record of PHC and other local providers who have served these residents faithfully and capably, or the important policies of the Maryland Health Care Commission (the "Commission") and the State to encourage transformational change in the health care system, *i.e.*, achieving the "triple aim." VNA's application has not demonstrated that its expansion plan will meet the needs of the public, nor is it consistent with general health planning principles, the purposes of Maryland's CON program, and, most importantly, Maryland law and regulation. Because VNA presents no evidence in support of a public need for its proposed geographic expansion, or about how it intends to serve the area, the Application must be denied.

## **II. PHC QUALIFIES AS AN "INTERESTED PARTY" IN THIS PROCEEDING AND THUS IS QUALIFIED TO SUBMIT THESE COMMENTS.**

Pursuant to COMAR § 10.24.01.08F(1) and the notice published at 44 Md. Reg. 1200 (Dec. 8, 2017), PHC qualifies for interested party status in the review of VNA's Application. As explained below, PHC operates a home health agency that serves residents in the Applicant's proposed expanded service area, and it will be adversely affected by the Applicant's project. Thus, PHC qualifies as an interested party and may submit written comments in this proceeding.

### **A. Peninsula Home Care**

PHC is a Medicare-certified, licensed home health agency that has been providing home health services to patients on Maryland's Lower Eastern Shore for more than thirty (30) years. PHC serves patients in this area's three southernmost counties: Wicomico, Worcester, and Somerset. (Dorchester County is not in its service area.) In 2017, PHC assisted more than 2,500 (unduplicated) patients and provided care during almost 51,000 visits. PHC has a proven track record of providing excellent care in the local community. For example, PHC has been named to the HomeCare Elite list for several years, participates in the Home Health Quality Improvement

National Campaign of the Centers for Medicare and Medicaid Services (“CMS”) for reduction in readmissions, has received several proclamations, including from Wicomico, Worcester, and Somerset Counties, is a member of the Salisbury Chamber of Commerce, and has a four star Quality of Patient Care rating from CMS. PHC is locally owned and operated, with offices in Salisbury (Wicomico County) and Ocean Pines (Worcester County). It is a joint venture of Peninsula Health Ventures, Inc., an affiliate of Peninsula Regional Health System (which includes the area’s largest hospital), and CHMG Home Health (a provider of home health management services on the East Coast), and it is the predominant provider of home health in Wicomico, Worcester and Somerset Counties.

**B. PHC is an “Interested Party” Authorized to Submit Written Comments in this CON Proceeding.**

Any “interested party” is entitled to file written comments in a CON proceeding. COMAR § 10.24.01.08F. An “interested party” includes “[a] person who can demonstrate to the reviewer that the person would be adversely affected, in an area over which the Commission has jurisdiction, by the approval of a proposed project.” § 10.24.01.01(B)(20)(e). An “adversely affected” person includes an entity that “[i]s authorized to provide the same service as the applicant, in the same planning region used for purposes of determining need under the State Health Plan [(or “SHP”)]” or that “[c]an demonstrate to the reviewer that the person could suffer a potentially detrimental impact from the approval of a project before the Commission, in an issue area over which the Commission has jurisdiction.” §§ 10.24.01.01(B)(2)(a) & (d). PHC qualifies as an interested party under both of these provisions.

Under the first provision (COMAR § 10.24.01.01(B)(2)(a)), PHC is authorized to provide the same service as VNA (Medicare-certified home health services) in the same planning region used to determine need under Chapter 10.24.16 of the SHP: the Lower Eastern Shore, comprised

of four Maryland counties: Dorchester, Somerset, Wicomico and Worcester. As noted above, PHC provides services in the last three of these counties (Wicomico, Worcester and Somerset). This alone makes PHC an interested party.

Under the second provision (COMAR § 10.24.01.01(B)(2)(d)), PHC asserts that it will be adversely affected by the Applicant's plan to "develop the entire Lower Eastern Shore region over a three-year period in order to achieve 10,000 visits annually." App. at 10. A common sense approach makes clear that potential patients and staff of PHC will be among those "captured" by VNA. By virtue of PHC's two physical locations on the Lower Eastern Shore (in Wicomico and Worcester Counties) and of its treatment of service area residents, PHC will inevitably lose referrals and, more importantly, valuable staff to, and will suffer financial harm as a result of, this project. PHC (and the other existing home health agencies on the Lower Eastern Shore) will clearly suffer "detrimental impact" within the meaning of COMAR § 10.24.01.01B(2)(d) if the Application is approved and if VNA achieves its annual volume projections.

For the above reasons, PHC qualifies as an "interested party" to this Application and CON review proceeding, and, as such, it submits these Comments. These Comments are particularly relevant in that PHC asserts that the Applicant has neither addressed nor meets essential provisions of the General Review Criteria (as defined below) and of the SHP. Therefore, the Applicant cannot justify the "public need" for this project.

### **III. THE APPLICATION DOES NOT MEET—AND IN SOME CASES DOES NOT EVEN ADDRESS—ESSENTIAL GENERAL REVIEW CRITERIA AND THEREFORE MAY NOT BE APPROVED.**

In the submission of any CON application, the applicant bears the burden of demonstrating "by a preponderance of the evidence" that the proposed project meets the applicable "General Review Criteria" found in COMAR § 10.24.01.08G(3). COMAR §

10.24.01.08G(1). Unless the applicant meets this burden, it may not obtain CON approval. In this instance, the Applicant does not meet this burden. In some cases, VNA does not even address essential General Review Criteria that are relevant to its Application.

As explained below, the Application's flaws reveal that VNA lacks an understanding or even a consideration of the concerns facing the residents of the Lower Eastern Shore. It appears that VNA, after receiving a CON to expand into the Upper Eastern Shore south of Cecil County and with a desire to extend its reach even further, filed an application that takes a "trust us" approach to many of the requirements. In doing so, VNA has tried to assure the Commission that many of these requirements either are met, without providing any asked for proof, or will be met, without demonstrating any thoughtful planning for how it will do so. As a result, PHC fears that VNA wants a CON in this area to provide care in the most densely populated and most economically advantageous portions of the Lower Eastern Shore, while ignoring the poorer, rural areas that dominate the region. This result will unfairly impact the region's residents and PHC, which has provided needed care to the residents of these largely poor and rural communities for more than thirty (30) years.

**A. The Applicant Has Not Demonstrated Consistency with the SHP.**

COMAR § 10.24.01.08(G)(3)(a) requires that an application be evaluated according to all relevant SHP "standards, policies, and criteria." The SHP for Home Health Agency Services (the "Home Health SHP") has specific standards in COMAR § 10.24.16.08 to be used in the review where, as here, an existing Maryland home health agency has applied to expand its services to additional jurisdictions.<sup>3</sup> VNA's Application is inconsistent with the policies and criteria set forth in the Home Health SHP. Thus, it is not approvable. Most importantly, the

---

<sup>3</sup> Because this is not a comparative review, we have not addressed the additional review criteria found in COMAR § 10.24.16.09 even though VNA provided responses to these criteria in its Application. App. at 20.

Applicant has ignored the need policies found in the Home Health SHP and also has overlooked the proposed project's impact on each existing home health agency authorized to serve the affected area under COMAR § 10.24.16.08G. These deficiencies are addressed in Sections III.B and III.E of these Comments, respectively.

Below, we have also addressed additional parts of this regulation to which we believe VNA failed to respond adequately. These requirements are at the heart of PHC's main concern, *i.e.*, that VNA has not demonstrated that it understands (or even cares to understand) the unique concerns facing the Lower Eastern Shore or that it wants to serve patients in all parts of this rural, economically depressed, and medically underserved region. PHC strongly believes that the "right" applicant in this area—*i.e.*, one who would be committed to serving people in every part of the region, regardless of economic status and geographic location—would take the time to cultivate a local presence well in advance of any CON being awarded or at least to understand the area and its people. VNA's responses to these requirements illustrate that it is not the "right" applicant, and they fuel PHC's concern that VNA will focus its efforts only in the region's most populated areas.

*1. VNA's inadequate responses to COMAR §§ 10.24.16.08A and B demonstrate its lack of understanding of the Lower Eastern Shore.*

Although VNA acknowledges that it wants to provide home health agency services in the Lower Eastern Shore, App at 11–12, it has not adequately responded to COMAR §§ 10.24.16.08A (Service Area) and 10.24.16.08B (Populations and Services) because it failed to understand, or attempt to understand, how this area and its population are different from everywhere else that VNA serves around the state. This is a fatal flaw in VNA's Application, as it demonstrates a lack of appreciation for the unique demographic conditions of the community—largely economically depressed, rural, and medically underserved—that make this

a particularly difficult population to serve, especially with a service that goes to the patient as opposed to having the patient come to a facility. For example, as shown in the charts found in **Exhibit 1**, this population is economically challenged. Somerset County is the poorest county in the state, with the lowest household median income (about \$35,000) and with the largest percent of people who live in poverty (almost 25%). The other three counties do not fare much better, as they are in the top nine (9) Maryland counties for lowest household median income, and Dorchester County and Wicomico County are also in the top five (5) Maryland counties with the highest percentage of people living in poverty. This particular area is also very rural. **Exhibit 1** shows that all four counties are in the state's top ten (10) least densely populated counties. Complicating matters further, Lower Eastern Shore residents face a shortage of medical providers in many areas. As **Exhibit 2** shows, this region's four counties are designated as "Medically Underserved Areas" or "Medically Underserved Populations," or both, by the federal Health Resources and Services Administration. As a fixture of the Lower Eastern Shore community, PHC is well-aware of—and capable of coping with—these difficulties. In contrast, VNA has no current plans to develop a strategy to deal with these issues.

In the Completeness Questions under the heading "Service Area," Commission Staff asked if VNA will open a satellite office in the Lower Eastern Shore, to which VNA responded that it would not be doing so. Completeness Questions Responses ("Responses") at 3. We understand that VNA does not open satellite offices and handles all business matters from its main office in Baltimore County. *Id*; *see also* App. at 12, 24. We also understand that VNA prefers to have "drop off sites" (which are not described) and to meet in local hotels or library conference rooms—which VNA would not look for on the Lower Eastern Shore until after a CON was awarded—for recruitment, training, and marketing purposes and for quarterly meetings. *See*

App. at 12, 24; Responses at 11–12. While that approach might be sufficient for VNA’s purposes in more urban areas of the state (particularly those close to its Baltimore home base), PHC believes that it is vitally important for a successful home health agency on the Lower Eastern Shore to have a well-established local presence. In addition to its main office in Salisbury (in Wicomico County), PHC has a branch office in Ocean Pines (in Worcester County). Although it does not have an additional branch office in Somerset County, PHC’s offices are no more than 33 miles and 49 minutes away from its most distant client in Crisfield, Somerset County.<sup>4</sup>

In contrast, VNA’s Baltimore office is more than 137 miles and more than 3 hours away from the same client, assuming (that is) that VNA intends to serve clients in such remote areas of the Lower Eastern Shore.<sup>5</sup> As the maps in **Exhibit 3** demonstrate, VNA has focused its efforts on Baltimore City and Baltimore County and most of the surrounding densely populated counties (Howard, Anne Arundel, and Prince George’s Counties). (**Exhibit 3A** displays the amount of clients that VNA served in FY 2014<sup>6</sup> in each of its authorized jurisdictions. **Exhibit 3B** layers this same information on a map that uses black dots to show the relative population density around the state of Maryland in 2014.<sup>7</sup>) Although VNA is authorized to serve other counties farther away from its home base in Baltimore County, the maps in **Exhibit 3** confirm that such areas are not its focus. (In fact, as of FY 2014, VNA has served no, or virtually no, patients in some of its authorized areas.) This centralized utilization pattern suggests that VNA may not actually plan to serve patients in the remote areas of the Lower Eastern Shore, including in Somerset County, which (as noted above) is one of the poorest and most rural areas in Maryland.

---

<sup>4</sup> MAPTITUDE, 2017.

<sup>5</sup> *Id.*

<sup>6</sup> There is no public data since 2014.

<sup>7</sup> To clarify, in **Exhibit 3B**, the black dots represent the total population of Maryland in 2014 (approximately 5 million people in total), not VNA clients. The VNA client counts for each jurisdiction are in the rectangular boxes.

VNA implied as much when it discussed, in response to a Staff question, its timeframe for serving the Lower Eastern Shore jurisdictions. Specifically, VNA stated that after first offering services in Dorchester and Wicomico Counties (*i.e.*, Cambridge and Salisbury) in 2018, it was VNA's "expectation at the end of 2018 to expand services to Worcester County and in 2019 or earlier to extend services to Somerset County *based on need and availability of staffing to adequately handle referrals.*" Responses at 13 (emphasis added). In other words, it appears that VNA will simply focus on the two westernmost and northern counties and worry about the poorest and more remote areas (particularly Somerset County) later, if at all. This approach is unacceptable.

PHC believes that there are many advantages to having an agency located in the community it serves, all of which contribute to providing better patient care. For example, this close proximity allows a home health agency's staff to form relationships with area physicians and referral sources, particularly the discharge planners at area hospitals. These relationships promote collaboration and innovation that enhance patient services, ultimately leading to better outcomes, including reduced inpatient hospitalizations and total cost of care. As one example, PHC regularly meets with discharge planners and other hospital staff to discuss all PHC home health patients who were readmitted to the hospital within 30 days in an attempt to determine the cause and improve care. PHC believes that an organization can only improve community based care if it is part of the community. Similarly, close proximity of the staff to patients allows for more immediate care, which is particularly important after hours and on weekends. According to the Alliance of Community Health Plans, a national leadership organization of innovative health plans and provider groups that deliver affordable, high-quality coverage and care, eighty percent (80%) of health is driven by socio-economic factors, health behaviors, and environmental

factors. See [www.achp.org/the-importance-of-community-health/](http://www.achp.org/the-importance-of-community-health/). As demonstrated by **Exhibits 1 and 2**, the socio-economic factors for much of this area are not favorable for good health. Having a local branch allows an agency's leaders, marketers, and clinical staff to become a part of the community and use their knowledge of these factors to create successful patient care plans. It also provides an agency with knowledge of local resources that can assist home bound patients and provide tools to improve their health, such as behavioral health access, local clinics, food banks, transportation services for doctor visits, and home improvements such as ramps. This is particularly critical in the lowest of the Lower Eastern Shore counties. **Exhibit 4** contains a list of such local resources with which PHC regularly works and collaborates to improve care, reduce hospital readmissions, reduce cost of care, and promote and sustain health and wellness in the communities it serves. Finally, a branch allows for more visibility of the agency and improves recruitment efforts, which is a high priority on the Lower Eastern Shore where medical providers are scarce in many areas. PHC has found that Eastern Shore locals prefer and respond better to care provided by "one of their own. Given VNA's reluctance to establish a branch office or other roots on the Lower Eastern Shore, PHC notes that VNA has refused to provide any evidence about how it intends to become a dedicated member of the local community.

2. *VNA has not made any effort to establish required community links.*

Under COMAR § 10.24.16.08I, an applicant must "document its links with hospitals, nursing homes, continuing care retirement communities, hospice programs, assisted living providers, Adult Evaluation and Review Services, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area." Specifically, an existing home health agency—like VNA—"shall provide documentation of these linkages in its existing service area *and document its work in forming such linkages before beginning operation in each new jurisdiction it is authorized to serve*" (emphasis added). VNA

barely responded to this requirement, mentioning only that it cannot accept “many referrals” from (unidentified) existing providers without a CON in the counties at issue and that certain (unidentified) insurance companies asked VNA to expand its services into the Lower Eastern Shore. App. at 19.<sup>8</sup> It did not provide any specific names of, or any letters of support from, such supportive insurance companies or providers.

Commission Staff noticed this lack of responsiveness and asked VNA to provide documentation of linkages in VNA’s existing service area (including Cecil County) and to “document its work in forming such linkages in Dorchester, Somerset, Wicomico and Worcester Counties.” Responses at 6. VNA’s response was even more unacceptable than its initial answer. Not only did it refuse to provide documentation of its existing linkages, but also it stated—in direct contrast to the spirit of the requirement—that its model is “to create linkages *after* being awarded a CON for the designated area in which it is sought.” Responses at 6 (emphasis added). At the very least, VNA should have been required to detail its plans to reach out to area providers, which is crucial in the Lower Eastern Shore, which (as illustrated above) suffers from a shortage of medical providers and also faces challenges travelling to patients given its low population density. It failed to take even that basic step. VNA’s refusal to follow the rules and get to know area providers further indicates its lack of plans to serve this difficult patient population. It also supports PHC’s concern that VNA wants a CON to expand into this area in order to cherry-pick the best patients in the region’s most populated areas, leaving all other difficult to serve patients to PHC and other existing agencies to care for.<sup>9</sup>

---

<sup>8</sup> See also *id.* at 12, 23 (again claiming that unnamed “current referral sources” and “Private Insurers” asked VNA to expand its services to the Lower Eastern Shore).

<sup>9</sup> On a related note, COMAR § 10.24.16.08J requires an applicant to document that it has a formal discharge planning process including “the ability to provide appropriate referrals to maintain continuity of care.” VNA responded only by pointing to its discharge planning protocol. App. at 19. It did not describe how it will create or maintain referral relationships in the local community, which is important for all of the reasons described above. VNA failed to meet its burden of persuasion.

**B. The Applicant Has Not Demonstrated Need.**

COMAR § 10.24.01.08G(3)(b) is quite directly titled “Need.” This criterion constitutes the cornerstone consideration in any CON review, as an assessment of public need comprises the very essence of the Commission’s purpose and obligation. The burden to prove public need by a preponderance of the evidence rests squarely upon the Applicant. This burden has not been met.

The need criterion states as follows: “The Commission shall consider the applicable analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider **whether the Applicant has established unmet needs of the population to be served and established that the proposed project meets those needs.**” § 10.24.01.08G(3)(b) (emphasis added). As described below, the Applicant does not meet its burden to conform to this criterion in several respects. First, VNA does not begin to address the question of whether there is “unmet need” for the service area population that it intends to serve. In fact, there is not. Second, the Applicant does not fully apply the policies, standards, and criteria set forth in the Home Health SHP.

*1. VNA has not established an unmet need for services.*

VNA has identified no unmet public need, which is a base requirement for a CON. VNA may argue that this analysis is unnecessary because the regulation first requires the Commission to consider the applicable analysis in the Home Health SHP, which allowed the Commission to open the Lower Eastern Shore region to potential new applicants under the recently updated version of COMAR § 10.24.16.04A(2) because the region’s four counties had a concentrated home health market according to an antitrust tool known as the Herfindahl-Hirschman Index (“HHI”).<sup>10</sup> However, a “need” for additional services does not automatically exist just because

---

<sup>10</sup> Interestingly, VNA’s Application does not specifically reference this HHI-based need criterion. Instead, VNA claims that it is “obvious[]” that the four counties in the Lower Eastern Shore Region “have insufficient choices due

the Commission opens up a region for review. That is particularly the case when the only reason the region was opened for docketing purposes was because an antitrust tool indicated a concentrated market share, with no indication that the area was in fact underserved. The CON application for home health services specifically requires applicants to “provide a *quantitative analysis* that, at a minimum, describes the Project’s expected service area; population size, characteristics, and projected growth; and projected home health utilization” even if the Home Health SHP “has identified need to establish an opportunity for review of CON applications in certain jurisdictions.” App. at 21 (emphasis added). Even though the Commission eschewed a traditional need analysis using a competition approach as a docketing matter when it updated the Home Health SHP, the Commission must still carry out its health planning mission, and it must do so by carefully scrutinizing any potential newcomer to ensure that its entrance into the marketplace is “needed” and will improve health care throughout the entirety of the region. This is especially true when the grant of a CON to a new provider in the region will foreclose the area to any other entrants for the next three years. See COMAR § 10.24.16.04A.

VNA’s minimal attempt to satisfy the need regulation and the CON application’s requirement fails. There is no explanation of the needs of the community or how VNA intends to provide care to the residents of the area. Instead, VNA’s argument for “need” is loosely strung together, and, as made clear in VNA’s Responses to the Staff’s Completeness Questions, is not easily supported by the requisite quantitative analysis. (In fact, PHC believes that the minimal quantitative analysis that VNA provided cannot be justified in light of the negligible population growth that the state of Maryland has projected through 2025 in the Lower Eastern

---

to the lack of active Medicare Certified Home Health Agencies.” App. at 22. VNA provides no proof to support this assertion and no analysis regarding how the expansion of VNA’s services will improve consumer choice throughout the region. We note that the Commission has not made a finding that the Lower Eastern Shore Region has insufficient choices due to the lack of active Medicare-certified home health agencies, which is not surprising given the fact that five agencies currently serve this community.

Shore, as described in more detail below.) VNA relies upon old data as well as broad—and, at least in part, inaccurate—statements to try to persuade the Commission to let it compete in this region. The Commission cannot ignore the requirement to show need. After all, the name of the end result of an application is a Certificate of Need, not a Certificate of Competition.

VNA’s theory on need seems to be based on the following points:

(1) Despite the fact that the total population in the four counties at issue was stagnant from 2010 to 2015, the 65 and older population has increased. App. at 21. To establish this point, VNA cited 2010 and 2015 Census data<sup>11</sup> (which it later said was “the only data available” to it, Responses at 7) and stated, “As compared to 2010, the increases of the percentage of 65 and greater population grew by 15.2%<sup>12</sup> . . . . Given the ever growing number of seniors reaching age 65 it is fair to say that the next 5 years will see a similar growth pattern if not greater.” App. at 21; *see also* App. at 22 (where the chart to which VNA referred—Chart 3—can be found). We do not believe that the 65 and older population will increase in this region by as much as VNA expects. According to the Maryland Department of Planning, the compounded annual growth rate (“CAGR”) for the 65 and older population—which is the heaviest user of home health services—for the Lower Eastern Shore between 2015 and 2025 is projected to be 2.7%. *See Exhibit 5*. The same data projects the CAGR for the entire population over the same time period to be less than 1%. *Id.* Based on this slow population growth alone, it is difficult to imagine how VNA could establish that its services are “needed” in this area, which is already being aptly served by five (5) home health agencies.<sup>13</sup>

---

<sup>11</sup> The chart to which VNA was referring listed 2010 and 2016 in the headings, as opposed to 2010 and 2015. App. at 22.

<sup>12</sup> VNA also suggested that this was consistent with national data, *see* App. at 22, which it did not provide.

<sup>13</sup> *See* n. 2.

(2) Utilization (as measured by total visits) increased by 21% in the four Lower Eastern Shore counties from 2011 and 2014 (the last year with available data). App. at 16–17, 18, 22, 27. As described in more detail below, VNA later criticized this data as “outdated” and “of little value in determining what future needs are for home health.” Responses at 7.

(3) VNA believes that utilization will continue to increase based on the following reasons: (1) there will be an “ever growing number of seniors reaching age 65,” App. at 21; *see also id.* at 22; (2) “national trends indicat[e] that today’s seniors prefer to age in place,” App. at 21; *see also id.* at 18; and (3) there is “increased usage of home health upon discharge from hospitals,” App. at 22. VNA failed to provide quantitative data to support these assertions, other than the fact that the elderly population is becoming a greater portion of the Lower Eastern Shore’s total population. (As noted, however, we believe that VNA’s data regarding the Lower Eastern Shore’s elderly population is outdated (or at least incomplete), given that the Maryland Department of Planning has projected the growth rate for this population to be only 2.7%, between 2015 and 2025, as shown in **Exhibit 5**.) Additionally, VNA stated many times that Chart 3 in its Application shows that the population is “aging in place.” *See* App. at 18, 21 & Responses at 5, 7. However, Chart 3 simply shows that the 65 and older population in the Lower Eastern Shore is growing at a faster rate than the region’s population at large.

Based on this “data,” and along with the claim that VNA experienced consistent annual increases of 5% or more on an agency-wide basis<sup>14</sup> over the past three years, VNA assumes that home health utilization in the Lower Eastern Shore would organically increase by at least 10% over a five-year period between 2015 through 2020, resulting in 10,000 visits VNA is projecting to provide by the end of CY 2020 without affecting other home health agencies in the Lower

---

<sup>14</sup> VNA clarified that the 5% year-to-year growth cited was an agency-wide number based on 14 counties being served. *See* Responses at 9.

Eastern Shore. App. at 16, 18, 23; *see also id.*, Table 2B (showing projected services in the region for 2017, 2018, and 2019) & Corrected Table 2B, Responses at 13 (showing projected services in the region for 2018, 2019, and 2020).<sup>15</sup> The fact that VNA's response was lacking in the required quantitative analysis was not missed by Staff. At least twice in the Completeness Questions, Staff asked VNA to provide additional details or evidence to support assertions related to its need argument. *See* Responses at 5 (asking for "details or evidence to support the assumptions used with your statement regarding 'organic growth' in utilization and the aging of the population"); *id.* at 7 ("As instructed by this standard, please provide a quantitative analysis that addresses the population size, characteristics, and projected growth in population for Dorchester, Somerset, Wicomico and Worcester Counties.") In response, VNA ignored the requests and reiterated data that it already provided. *See* Responses at 5, 7.

Even worse, VNA criticized some of its previously-provided data and made false assertions. As noted above, an important piece in VNA's need argument was the "fact" that a 21% increase in home health visits occurred in the Lower Eastern Shore between 2011 and 2014. *See* App. at 16–17, 22. However, as Staff pointed out, this data does not show consistent growth in all counties in all years. Responses at 7. When Staff pressed VNA regarding this data, VNA criticized the quantitative data further, not just the specific data in question (which it said was "outdated" and limited in time scope), but also in general, claiming that "[h]istoric utilization trends are of little value in determining what future needs are for home health." *Id.* This ignores the fact that the Commission requires applicants to document that "[u]tilization projections are consistent with observed historic trends of HHAs in each jurisdiction for which the applicant seeks authority to provide home health agency services." App. at 16.

---

<sup>15</sup> VNA's Table 2B is missing the required total unduplicated client count, in the original and corrected versions.

Finally, VNA tried to deflect the Commission's attention from its weak argument by suggesting that its services are needed because "many agencies focus on accepting Medicare cases and do not accept traditional insurers." *Id.* It reiterated this point when it stated in response to a separate question, "VNA of Maryland accepts a significant amount of [unidentified] private insurers that other [unidentified] home health agencies do not accept. Therefore, there is a certain amount of cases that are currently not being accepted because those [unidentified] providers do not accept the same [unidentified] insurance carriers that VNA of Maryland will accept." Responses at 9–10. We note that VNA did not provide a list of or otherwise identify such insurers or any evidence of their market share in the affected area. In contrast to this statement, PHC accepts almost all traditional insurers that do business in the area. **Exhibit 6** lists all of the insurances that PHC accepts. Furthermore, PHC's payor mix with respect to Medicare and commercial patients is comparable to the information that VNA reported regarding its current agency-wide payor mix as percent of total visits, suggesting that PHC and VNA, in fact, accept a comparable amount of insurance carriers: Commercial insurance accounts for about 25-30% of PHC's and VNA's current visits, while Medicare accounts for 65-70%.<sup>16</sup> See Application at Table 3, § 4B.

In addition to not demonstrating need for its proposed geographic expansion on the Lower Eastern Shore, VNA provided no data or information concerning its operations on the Upper Eastern Shore or in other rural jurisdictions in the State. The Applicant simply asserts that 10,000 annual visits are needed and will be provided by VNA to the residents of the Lower

---

<sup>16</sup> VNA's projections for the Lower Eastern Shore show a significant uptick in the amount of commercial patients that it plans to see. Specifically, VNA anticipates commercial insurance (including Blue Cross) to account for almost 40% of its total visits on the Lower Eastern Shore, with Medicare only accounting for about 60%. See *id.* at Table 4, § 4B. VNA's apparent focus on commercial patients on the Lower Eastern Shore contradicts another main part of its need-based argument, *i.e.*, that its services are needed in this area because the 65 and older population (on Medicare) is increasing and aging in place.

Eastern Shore by FY 2020, with no discussion whatsoever of the numbers of actual VNA clients served or visits provided in each of its authorized jurisdictions, particularly in rural areas. At a minimum, VNA could have demonstrated the numbers of home health agency clients that it serves in Washington, St. Mary's, Calvert, Charles, Kent, Queen Anne's, Talbot and Caroline counties, and the volume of services it has provided in such areas. We note that VNA's historical record—as illustrated in the **Exhibit 3** maps—suggests that its commitment to its authorized four Western Shore rural jurisdictions is insignificant, comprising less than 6% of VNA's total clients in FY 2014. This dismal track record outside the metropolitan areas provides some insight into the attention that VNA may give to the Lower Eastern Shore counties.

2. *VNA does not fully apply the policies, standards, and criteria set forth in the Home Health SHP.*

There is a public need policy set forth in the Home Health SHP (COMAR 10.24.16) that must be applied to applications for additional home health agency providers. Importantly, this policy requires an applicant to demonstrate that:

- additional need for a new home health agency is justified;
- its proposed project is likely to best meet that additional need; and
- existing markets can absorb new entrants without destabilizing the existing base of home health agencies and without straining the labor markets or other resources.<sup>17</sup>

The Applicant simply ignores this policy, perhaps recognizing that there is no public need for additional home health agencies on the Lower Eastern Shore and that none can be proven.

Instead, the Application focuses on capturing existing market share and redirecting referrals away from existing providers that have demonstrated their faithful and capable ability to

---

<sup>17</sup> We recognize that this language comes from a section of the Home Health SHP regarding preference rules and comparative reviews. See COMAR § 10.24.16.02E (p. 6). Even if this is not a comparative review, the principles still apply.

address growing home health care agency volumes of care. VNA plans to do so by encouraging yet-to-be-identified local area physicians and other providers to re-route referrals currently sent to existing home health agencies to VNA. Shifting market share from the area's existing home health providers to VNA is not the goal of the CON review process and does not equate to "need" for a new provider.

**C. The Applicant Has Not Demonstrated—and Cannot Demonstrate—that Its Proposal Is More Cost Effective Than Maintaining the Status Quo.**

The Application also should be denied because VNA has not met COMAR § 10.24.01.08G(3)(c), which requires the Commission to compare the cost effectiveness of the proposed project with other alternatives for providing the service. Despite having the burden to demonstrate that its proposal is more cost effective than those alternatives, VNA provided no cost analysis and no alternatives to its expansion project, either in its Application, *see* App. at 23–24, or in its Responses to Staff's Completeness Questions, *see* Responses at 9. Instead, it skirted the requirement by making general statements about the cost-effectiveness of home care.

The key alternative that VNA failed to address is that existing agencies could continue to provide the proposed services that VNA seeks to offer. Even if VNA had considered this alternative, it could not have met this requirement because it cannot demonstrate that its proposal: (a) meets an unmet need and thus resolves a problem of patient access and choice; (b) is the most cost effective way of resolving this (non-existent) problem; or (c) if approved, will reduce health care system costs.

To serve as a cost effective alternative, VNA first must show that there is insufficient access and choice among residents and that it can address these problems more cost-effectively. As argued above, VNA failed to identify an unmet need for the proposed project. Based on the historic trends in growth of existing home health utilization (growth that VNA embraced to

justify its expansion into the Lower Eastern Shore), existing treatment capacity is sufficient. There are no waiting lists for services or access barriers, and home health utilization keeps growing slowly, provided by local agencies that are part of the community served. Indeed, the Applicant intends to extend into at least a portion of this market to draw patients away from existing providers that have already demonstrated their capabilities to address growing needs. Adding one more home health agency would not serve any unmet demand imposed by the system as a whole. In fact, adding an additional unneeded provider, with no evidence of any local market knowledge and no demonstrated track record for addressing the local community's needs, will only destabilize the existing home health agencies. In addition, VNA's implied assumption that it can provide cost-effective care because of its state-wide presence neglects to account for the transformational initiatives in providing community based care and for the demand for local coordination of services to assure overall cost-effectiveness. Being attuned to the unique demands of the community and all of its available services—not just health care services—is critical in the new health care environment, and community based care is difficult to provide if a provider is not part of the community.

Finally, the Commission should assess the potential impact that the proposed expansion will have on the Commission's and the State's policies to achieve the "triple aim" of improving the experience of **care**, improving the **health** of populations, and reducing per capita **costs** of **health care**. The revenues of all Medicare providers, including those associated with home health services provided to fee-for-service Medicare beneficiaries, are to be monitored and regulated by the Maryland Health Services Cost Review Commission ("HSCRC") under the new agreement with the Centers for Medicare and Medicaid Services ("CMS") to commence on January 1, 2019. Through this project, VNA will move patients away from PHC and other home

health agencies, which have referral agreements with Maryland hospitals to ensure the cost-effective delivery of acute and post-acute care services to Medicare patients. VNA has provided no evidence in its Application that it intends to assure continuity in discharge planning among local physicians, hospitals, and post-acute care providers<sup>18</sup> or to foster continued alignment of financial incentives to those providers that are committed to cost-effective care delivery across the care spectrum. In contrast, PHC has these established referral relationships within the health care and social services systems on the Lower Eastern Shore. (Please see **Exhibit 4** for a list of local resources with which PHC has established relationships.) For example, PHC has local staff members who are dedicated to providing care coordination services in every county it serves. These staff members coordinate with referral sources, communicate with patients and their families/caregivers, communicate with the patients' physicians when necessary, and also assist with other non-medical, but necessary, services, such as transportation or language translation. These services are critical in any area, but absolutely essential in an area with the socio-economic situation found in the Lower Eastern Shore counties.

PHC submits that the Commission, in consultation with the HSCRC, should explicitly address how the Global Budget Revenue (or "GBR") system under the transformational CMS agreement should account for the anticipated financial impact of this proposal, where home health agency referrals from Peninsula Regional Medical Center will shift from its affiliated home health agency (PHC) to an unaffiliated agency (VNA). The Commission and HSCRC should recognize the disruption caused by the Applicant's proposal and its potential negative impacts. All of the above argues against the cost effectiveness assertions the Applicant has presented without support and should result in the denial of the Application.

---

<sup>18</sup> See n. 9.

**D. The Applicant Has Not Demonstrated a Proper Foundation for Asserting Viability.**

Under COMAR § 10.24.01.08G(3)(d), the Commission must consider the availability of financial and nonfinancial resources—including community support—necessary to implement and to sustain the project. Importantly, it appears that VNA lacks the community’s support for its proposed expansion, as indicated by the lack of any letters of support from organizations in the local community. Although not required, such letters are customarily submitted as part of a CON application to show how community leaders view the proposal.

**E. VNA Does Not Analyze the Proposal’s Impact on Existing Service Area Providers—including PHC—as Required.**

Highlighting its importance, the impact criterion is a part of the Commission’s regulations and a standard for review under the SHP. *See* COMAR § 10.24.01.08G(3)(f) (requiring applicants to “provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system”); § 10.24.16.08G (requiring applicants to “address the impact of its proposed home health agency service on each existing home health agency authorized to serve each jurisdiction or regional service area affected by the proposed project,” which shall “include impact on existing HHA’ caseloads, staffing and payor mix”). Given that need and impact are two sides of the same coin, VNA’s flawed need argument has resulted in an overly simplistic and naïve theory as to the impact on existing providers. As a result, the Commission has no basis to find that VNA has satisfied this impact requirement.

In sum, VNA defies reality by asserting that there will be “*no negative impact* to either caseload, staffing and/or payor mix to the existing home health agencies” in the Lower Eastern Shore. App. at 18 (emphasis added). This naïve statement is based on its assumption (without

sufficient quantitative evidence, as demonstrated above) that a 10% organic growth in the utilization need for the four counties by the end of 2020 will result in 10,000 new visits per year in this jurisdiction to be served by VNA. App. at 18; *see also* App. at 27–28. There is no discussion as to whether any of these new 10,000 visits could otherwise be served by the existing providers and how the existing market share of the existing providers would be decreased by VNA’s entrance into the region. Staff recognized that VNA failed to meet its burden on impact and asked it—again—to provide an analysis as to the “potentially adverse impact” that VNA will have on the volume of services provided by all existing home health providers in the four Lower Eastern Shore counties. Again, VNA failed to respond, suggesting instead (incorrectly) that it had already answered the question. Responses at 9.

PHC believes that the entrance of VNA in the Lower Eastern Shore market will have a significant impact on its future caseload, in terms of actual patients served and its market share, at least in Wicomico County. Even if VNA focuses its efforts on Wicomico and Dorchester Counties,<sup>19</sup> PHC will feel its effects throughout the entirety of its business. PHC counts on the revenue that it makes in Wicomico County to help it provide services in less economically advantageous parts of the Lower Eastern Shore. If PHC loses existing patients in Wicomico County to VNA, it will hinder its ability to provide the same level of service around the region. Similarly, if PHC’s projected growth is stunted in Wicomico County due to VNA’s entrance, then it also will be limited in its growth potential in other parts of the Lower Eastern Shore. Given PHC’s doubt that VNA will serve patients in remote areas of the region, any decrease in PHC’s services in this area could have a large impact.

As noted above, VNA stated that there would be no negative impact on the staffing of any existing provider. App. at 18. Staff came back to this issue in its Completeness Questions,

---

<sup>19</sup> As stated previously, PHC does not serve patients in Dorchester County.

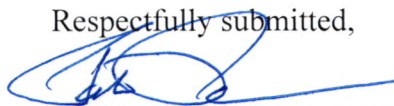
asking VNA to “provide a response that addresses impact on staffing and not adversely taking qualified personnel from existing health care providers in the Lower Eastern Shore.” Responses at 5. VNA responded by touting its high employee retention rate elsewhere and its H1B visa and green card holder programs. *Id.* at 6. It also suggested that it would find “opportunities for existing personnel in the bordering areas of Lower Eastern Shore and accommodate[e] personnel that would like to reside within the same area.” Responses at 6; *see also* App. at 26 (claiming that “personnel have expressed interest in relocating to the area”). It also stated elsewhere that it had “existing personnel who reside within the Lower Eastern Shore area.” App. at 26. Without any proof other than these simple assertions, we find it highly unlikely that VNA has many existing personnel who want to relocate to the Lower Eastern Shore or who reside in the Lower Eastern Shore (especially in its southernmost reaches) and work in any of the counties that VNA currently serves, given that VNA only recently received a CON to expand into the neighboring counties of the Upper Eastern Shore (other than Cecil County). Additionally, anyone who is familiar with the Lower Eastern Shore would have expected VNA’s response to at least mention that much of this area is considered a medically underserved area, meaning that healthcare professionals are scarce. (See **Exhibit 2**, a map showing that almost the entire area has a health manpower problem.) This creates additional difficulties with recruitment and retention, which PHC may not fully appreciate considering its apparent lack of information about the area. Given that there are a limited number of providers on the Lower Eastern Shore, PHC finds it highly unlikely that VNA’s presence will not affect its staffing, especially in Wicomico County.

## *CONCLUSION*

The Application presents questions central to the Commission's authority and purpose: whether an institution's internal business goals and a simple desire for more competition shall prevail over the assessment of public need and whether such goals may outweigh public need in the Commission's deliberations. In maintaining focus on the health care system, its existing providers, and, especially, its patient population, the CON regulatory framework requires all CON applicants to address and demonstrate public need through conformance with the General Review Criteria and the SHP. The Application does not demonstrate public need or conform to the other essential policies, review criteria, and standards in the Home Health SHP or in the General Review Criteria. The Applicant presents a business plan for increased market share that necessitates reductions in the future volumes of care provided by existing home health agencies, including PHC, but it does not present its case in a manner consistent with applicable CON requirements or with an appropriate concern for all citizens throughout the entirety of the service area. Competition plays its role after the CON process determines whether a proposed applicant's services are needed by the population. It cannot be allowed to replace the Applicant's requirement to demonstrate that a need exists for its services.

PHC respectfully requests that the Commission take the foregoing Comments into consideration and deny VNA's Application.

6  
Respectfully submitted,



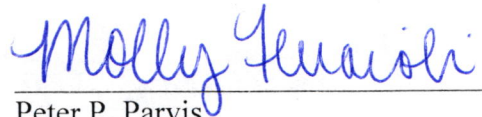
Peter P. Parvis  
Molly E. G. Ferraioli  
Miles & Stockbridge P.C.  
100 Light Street  
Baltimore, Maryland 21202

Counsel for Peninsula Home Care, LLC

## CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of January, 2018, a copy of the foregoing Interested Party Comments of Peninsula Home Care, LLC was sent by electronic mail and by first class mail, postage prepaid, to:

Barry M. Ray  
Chief Executive Officer  
VNA of Maryland  
7008 Security Boulevard  
Suite 300  
Baltimore, Maryland 21244  
[b.ray@vnamd.com](mailto:b.ray@vnamd.com)



---

Peter P. Parvis  
Molly E. G. Ferraioli

### AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Interested Party Comments of Peninsula Home Care, LLC and its attachments are true and correct to the best of my knowledge, information, and belief.

*Nancy Bagwell*

\_\_\_\_\_  
Name: Nancy P. Bagwell

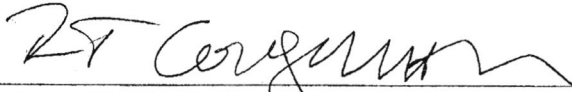
Title: Area Director of Operations for Maryland and Delaware  
Peninsula Home Care, LLC

\_\_\_\_\_  
1/8/18

January 8, 2018

### AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Interested Party Comments of Peninsula Home Care, LLC and its attachments are true and correct to the best of my knowledge, information, and belief.



Name: Richard J. Coughlan  
Title: Senior Manager  
DHG Healthcare

1/8/18  
January 8, 2018

**INTERESTED PARTY COMMENTS OF  
PENINSULA HOME CARE, LLC**

**LIST OF EXHIBITS**

1. Lower Eastern Shore Demographic Data
2. Map of Lower Eastern Shore Medically Underserved Areas and Medically Underserved Populations
3. Maps of VNA Clients Served in FY 2014
4. PHC's List of Local Resources for Collaboration
5. Lower Eastern Shore Population Estimates and Projections
6. Insurances Accepted by PHC

## **EXHIBIT 1**

### **Lower Eastern Shore Demographic Data**

*See attached.*

Source: 2010 United States Census; 2011-2015 American Community Survey; County Population Projections, Dept. of Planning (Maryland).

## **Demographic Data Sorted by Population Density 2020**

Name	Land Area (Sq. Miles)	HH_Median income	Median family income	Civ		Civ		Civ		Civ		Civ		Pct in		Pct in		Pct in		Pop	
				Noninst_ w/Health Ins	Noninst_ w/Health Ins_Private	Noninst_ w/Health Ins_Public	Noninst_ w/Health Ins	Noninst_ w/Health Ins	Noninst_ w/Health Ins	Noninst_ w/Health Ins	Noninst_ w/Health Ins	Noninst_ w/Health Ins	Noninst_ w/Health Ins	poverty_A	poverty_A	poverty_A	poverty_A	poverty_A	poverty_A	2010_Pop	2020_Pop
Garrett MD	647.102966	45432	55188	26202	18345	12144	3129	484	9.577942	12.41244	9.973582	30097	30700	47	47						
Dorchester MD	540.765137	47093	60012	29352	19814	14643	2743	224	11.91978	16.45404	14.36802	32618	35000	60	65						
Kent MD	277.030334	58147	70760	18031	13332	8336	1541	66	6.413202	11.15159	8.386427	20197	21500	73	78						
Somerset MD	319.723267	35154	46947	18975	11940	9938	2258	73	20.34441	24.67711	22.58265	26470	27900	83	87						
Caroline MD	319.419403	52465	60299	28621	19886	13306	3648	380	12.34715	15.8398	13.51936	33066	36650	104	115						
Worcester MD	468.280548	56773	68558	46047	34319	22197	4860	432	7.648725	10.96989	8.450005	51454	56400	110	120						
Queen Anne's MD	371.907471	85963	100577	45546	38578	13819	2469	210	5.224502	7.467844	6.09683	47798	53600	129	144						
Talbot MD	268.538361	58228	73410	33769	26958	15007	3640	292	7.779298	11.24191	8.581326	37782	40860	141	152						
Allegany MD	424.157776	40551	55405	63185	45233	29751	4978	369	11.68756	18.03323	12.51529	75087	75650	177	178						
Wicomico MD	374.443512	52278	63231	89858	66614	35103	9999	756	11.14928	15.93504	11.49808	98733	109200	264	292						
Cecil MD	346.27301	66396	80146	92854	73502	30671	7968	1279	6.776313	10.11839	8.226227	101108	118500	292	342						
St. Mary's MD	357.180023	86987	98260	100069	85696	26897	6834	1195	6.149742	7.851657	5.990011	105151	125150	294	350						
Washington MD	457.779785	56228	67201	129173	97080	51236	11791	1375	9.662476	12.89132	10.57771	147430	163100	322	356						
Charles MD	457.74881	90607	102498	142159	123506	36519	7977	1077	6.013724	7.894405	6.406555	146551	174350	320	381						
Frederick MD	660.221008	83700	98064	222963	195078	55373	16144	1793	4.697638	6.841577	5.059606	233385	267650	353	405						
Carroll MD	447.594666	85385	101208	157596	139852	39617	7834	997	3.401983	5.61599	3.649249	167134	183600	373	410						
Calvert MD	213.151978	95828	109288	83382	72911	21589	5404	681	3.540546	5.837117	3.661491	88737	95600	416	449						
Harford MD	437.08905	80465	93217	233917	201667	66299	12362	1353	6.241509	8.044603	6.472938	244826	267350	560	612						
MARYLAND	9707.241	74551	90089	5313662	4318257	1679957	523072	52573	6.968528	9.963418	7.544646	5773552	6216160	595	640						
Howard MD	250.741074	110238	128504	283478	255333	58334	18120	2548	3.794309	5.212723	4.036265	287085	317650	1,145	1,267						
Anne Arundel MD	414.901794	89860	102606	500991	436741	134164	34180	3663	3.794877	5.854311	3.954338	537656	567750	1,296	1,368						
Baltimore MD	598.30188	67095	82329	748969	612956	241852	65828	7121	6.333986	9.407107	6.88639	805029	847000	1,346	1,416						
Prince George's MD	482.690857	74260	85445	763642	607683	242127	122451	11163	6.914567	9.638143	7.360196	863420	902500	1,789	1,870						
Montgomery MD	491.254425	99435	117798	905656	777342	231897	103522	9248	4.557234	6.717871	4.813867	971777	1065600	1,978	2,169						
Baltimore City MD	80.943703	42241	51032	549227	343891	269138	63392	5794	18.9569	23.66267	20.8806	620961	632900	7,672	7,819						

## Demographic Data Sorted by Percent of All People in Poverty

				Civ	Civ	Civ		Civ			Pct in						
			Median	Noninst_	Noninst_w/	Noninst_w/	Civ		Noninst_<	Pct in	Pct in	poverty_P			Pop	Pop	
Name	Land Area (Sq. Miles)	HH_Median income	family income	w/Health Ins	Health Ins_Private	Health Ins_Public	Noninst_No Health Ins	18_No Health Ins	poverty_A	poverty_A	poverty_A	eople in families	2010_Pop	2020_Pop	Density 2010	Density 2020	
Somerset MD	319.723267	35154	46947	18975	11940	9938	2258	73	20.34441	24.67711	22.58265	26470	27900	83	87		
Baltimore City MD	80.943703	42241	51032	549227	343891	269138	63392	5794	18.9569	23.66267	20.8806	620961	632900	7,672	7,819		
Allegany MD	424.157776	40551	55405	63185	45233	29751	4978	369	11.68756	18.03323	12.51529	75087	75650	177	178		
Dorchester MD	540.765137	47093	60012	29352	19814	14643	2743	224	11.91978	16.45404	14.36802	32618	35000	60	65		
Wicomico MD	374.443512	52278	63231	89858	66614	35103	9999	756	11.14928	15.93504	11.49808	98733	109200	264	292		
Caroline MD	319.419403	52465	60299	28621	19886	13306	3648	380	12.34715	15.8398	13.51936	33066	36650	104	115		
Washington MD	457.779785	56228	67201	129173	97080	51236	11791	1375	9.662476	12.89132	10.57771	147430	163100	322	356		
Garrett MD	647.102966	45432	55188	26202	18345	12144	3129	484	9.577942	12.41244	9.973582	30097	30700	47	47		
Talbot MD	268.538361	58228	73410	33769	26958	15007	3640	292	7.779298	11.24191	8.581326	37782	40860	141	152		
Kent MD	277.030334	58147	70760	18031	13332	8336	1541	66	6.413202	11.15159	8.386427	20197	21500	73	78		
Worcester MD	468.280548	56773	68558	46047	34319	22197	4860	432	7.648725	10.96989	8.450005	51454	56400	110	120		
Cecil MD	346.27301	66396	80146	92854	73502	30671	7968	1279	6.776313	10.11839	8.226227	101108	118500	292	342		
MARYLAND	4524.457802	74551	90089	5313662	4318257	1679957	523072	52573	6.968528	9.963418	7.544646	1275003	1348360	282	298		
Prince George's MD	482.690857	74260	85445	763642	607683	242127	122451	11163	6.914567	9.638143	7.360196	863420	902500	1,789	1,870		
Baltimore MD	598.30188	67095	82329	748969	612956	241852	65828	7121	6.333986	9.407107	6.88639	805029	847000	1,346	1,416		
Harford MD	437.08905	80465	93217	233917	201667	66299	12362	1353	6.241509	8.044603	6.472938	244826	267350	560	612		
Charles MD	457.74881	90607	102498	142159	123506	36519	7977	1077	6.013724	7.894405	6.406555	146551	174350	320	381		
St. Mary's MD	357.180023	86987	98260	100069	85696	26897	6834	1195	6.149742	7.851657	5.990011	105151	125150	294	350		
Queen Anne's MD	371.907471	85963	100577	45546	38578	13819	2469	210	5.224502	7.467844	6.09683	47798	53600	129	144		
Frederick MD	660.221008	83700	98064	222963	195078	55373	16144	1793	4.697638	6.841577	5.059606	233385	267650	353	405		
Montgomery MD	491.254425	99435	117798	905656	777342	231897	103522	9248	4.557234	6.717871	4.813867	971777	1065600	1,978	2,169		
Anne Arundel MD	414.901794	89860	102606	500991	436741	134164	34180	3663	3.794877	5.854311	3.954338	537656	567750	1,296	1,368		
Calvert MD	213.151978	95828	109288	83382	72911	21589	5404	681	3.540546	5.837117	3.661491	88737	95600	416	449		
Carroll MD	447.594666	85385	101208	157596	139852	39617	7834	997	3.401983	5.61599	3.649249	167134	183600	373	410		
Howard MD	250.741074	110238	128504	283478	255333	58334	18120	2548	3.794309	5.212723	4.036265	287085	317650	1,145	1,267		

## **Demographic Data Sorted by Household Median Income**

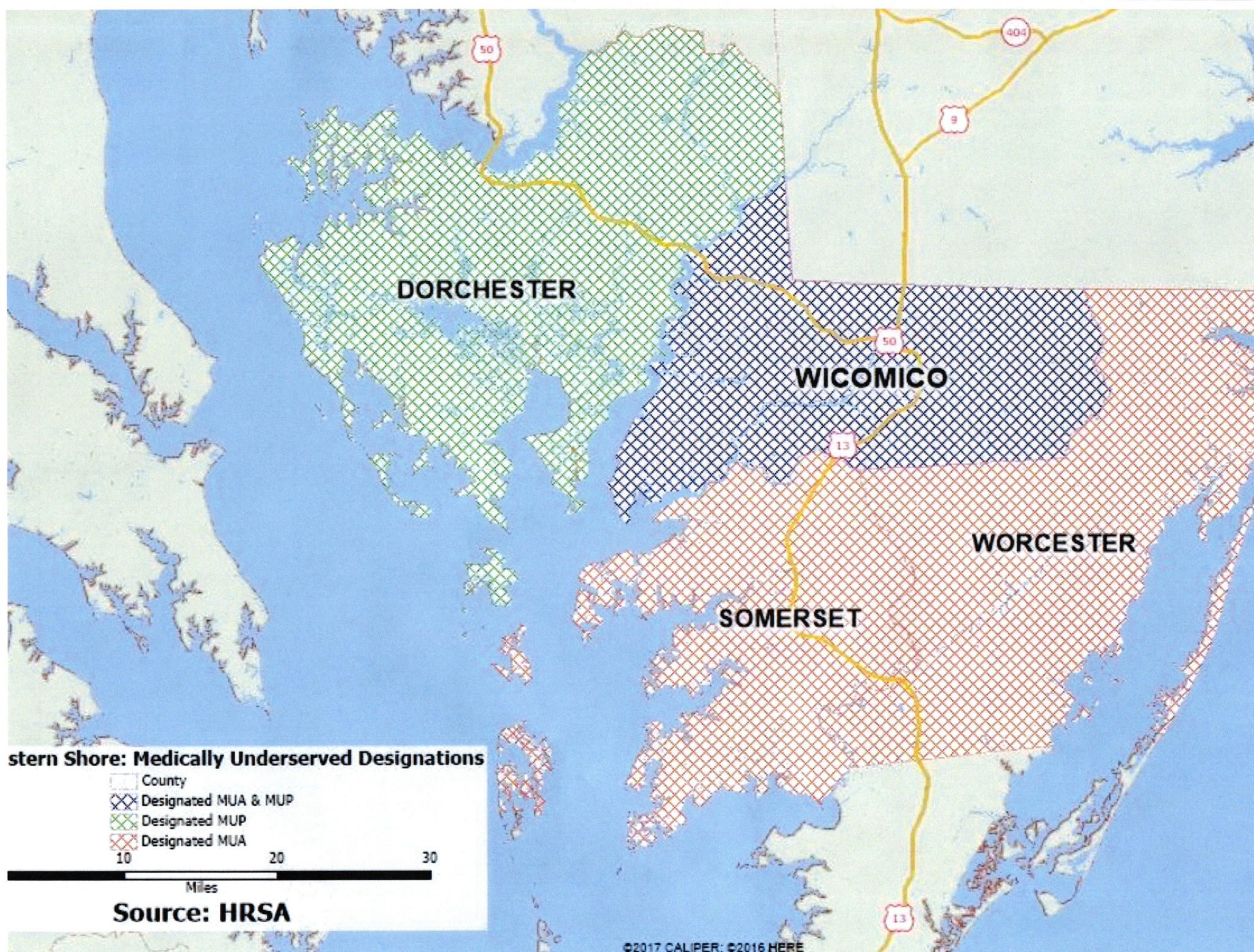
Name	Land Area (Sq. Miles)	HH_Median income	Median family income	Civ Noninst_ w/Health Ins	Civ Noninst_w/ Health Ins_Private	Civ Noninst_w/ Health Ins_Public	Civ Noninst_No Health Ins	Civ Noninst_< 18_No Health Ins	Pct in poverty_A ll families	Pct in poverty_A ll people	Pct in poverty_P eople in families	2010_Pop ulation	2020_Pop ulation	Pop Density 2010	Pop Density 2020
				Ins	Ins_Private	Ins_Public	Health Ins	Health Ins	poverty_A ll families	poverty_A ll people	poverty_P eople in families				
Somerset MD	319.723267	35154	46947	18975	11940	9938	2258	73	20.34441	24.67711	22.58265	26470	27900	83	87
Allegany MD	424.157776	40551	55405	63185	45233	29751	4978	369	11.68756	18.03323	12.51529	75087	75650	177	178
Baltimore City MD	80.943703	42241	51032	549227	343891	269138	63392	5794	18.9569	23.66267	20.8806	620961	632900	7,672	7,819
Garrett MD	647.102966	45432	55188	26202	18345	12144	3129	484	9.577942	12.41244	9.973582	30097	30700	47	47
Dorchester MD	540.765137	47093	60012	29352	19814	14643	2743	224	11.91978	16.45404	14.36802	32618	35000	60	65
Wicomico MD	374.443512	52278	63231	89858	66614	35103	9999	756	11.14928	15.93504	11.49808	98733	109200	264	292
Caroline MD	319.419403	52465	60299	28621	19886	13306	3648	380	12.34715	15.8398	13.51936	33066	36650	104	115
Washington MD	457.779785	56228	67201	129173	97080	51236	11791	1375	9.662476	12.89132	10.57771	147430	163100	322	356
Worcester MD	468.280548	56773	68558	46047	34319	22197	4860	432	7.648725	10.96989	8.450005	51454	56400	110	120
Kent MD	277.030334	58147	70760	18031	13332	8336	1541	66	6.413202	11.15159	8.386427	20197	21500	73	78
Talbot MD	268.538361	58228	73410	33769	26958	15007	3640	292	7.779298	11.24191	8.581326	37782	40860	141	152
Cecil MD	346.27301	66396	80146	92854	73502	30671	7968	1279	6.776313	10.11839	8.226227	101108	118500	292	342
Baltimore MD	598.30188	67095	82329	748969	612956	241852	65828	7121	6.333986	9.407107	6.88639	805029	847000	1,346	1,416
Prince George's MD	482.690857	74260	85445	763642	607683	242127	122451	11163	6.914567	9.638143	7.360196	863420	902500	1,789	1,870
MARYLAND	9707.241	74551	90089	5313662	4318257	1679957	523072	52573	6.968528	9.963418	7.544646	5773552	6216160	595	640
Harford MD	437.08905	80465	93217	233917	201667	66299	12362	1353	6.241509	8.044603	6.472938	244826	267350	560	612
Frederick MD	660.221008	83700	98064	222963	195078	55373	16144	1793	4.697638	6.841577	5.059606	233385	267650	353	405
Carroll MD	447.594666	85385	101208	157596	139852	39617	7834	997	3.401983	5.61599	3.649249	167134	183600	373	410
Queen Anne's MD	371.907471	85963	100577	45546	38578	13819	2469	210	5.224502	7.467844	6.09683	47798	53600	129	144
St. Mary's MD	357.180023	86987	98260	100069	85696	26897	6834	1195	6.149742	7.851657	5.990011	105151	125150	294	350
Anne Arundel MD	414.901794	89860	102606	500991	436741	134164	34180	3663	3.794877	5.854311	3.954338	537656	567750	1,296	1,368
Charles MD	457.74881	90607	102498	142159	123506	36519	7977	1077	6.013724	7.894405	6.406555	146551	174350	320	381
Calvert MD	213.151978	95828	109288	83382	72911	21589	5404	681	3.540546	5.837117	3.661491	88737	95600	416	449
Montgomery MD	491.254425	99435	117798	905656	777342	231897	103522	9248	4.557234	6.717871	4.813867	971777	1065600	1,978	2,169
Howard MD	250.741074	110238	128504	283478	255333	58334	18120	2548	3.794309	5.212723	4.036265	287085	317650	1,145	1,267

## **EXHIBIT 2**

### **Map of Lower Eastern Shore Medically Underserved Areas and Medically Underserved Populations**

*See attached.*

Source: Health Resources and Services Administration.



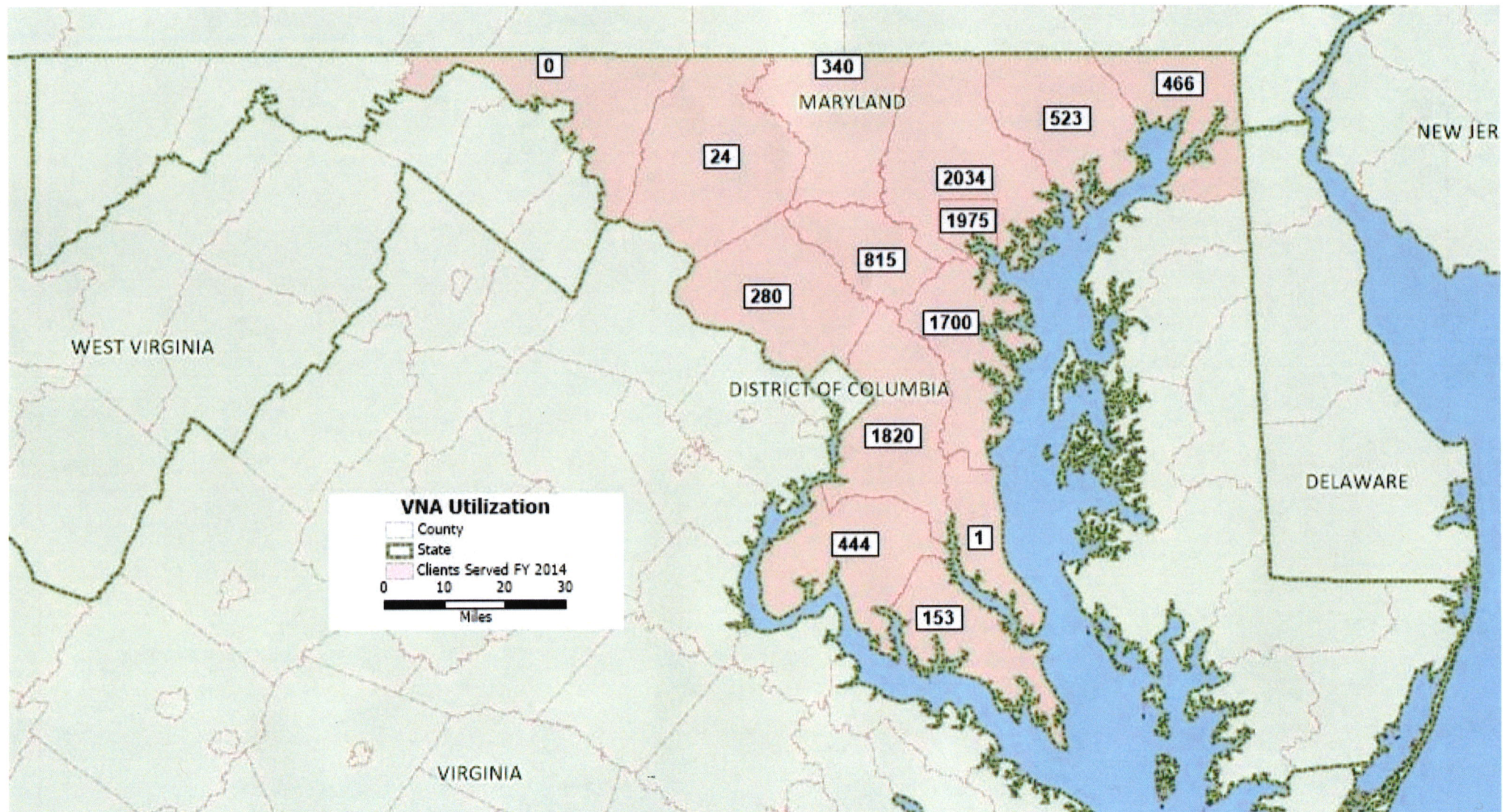
### **EXHIBIT 3**

#### **Maps of VNA Clients Served in FY 2014**

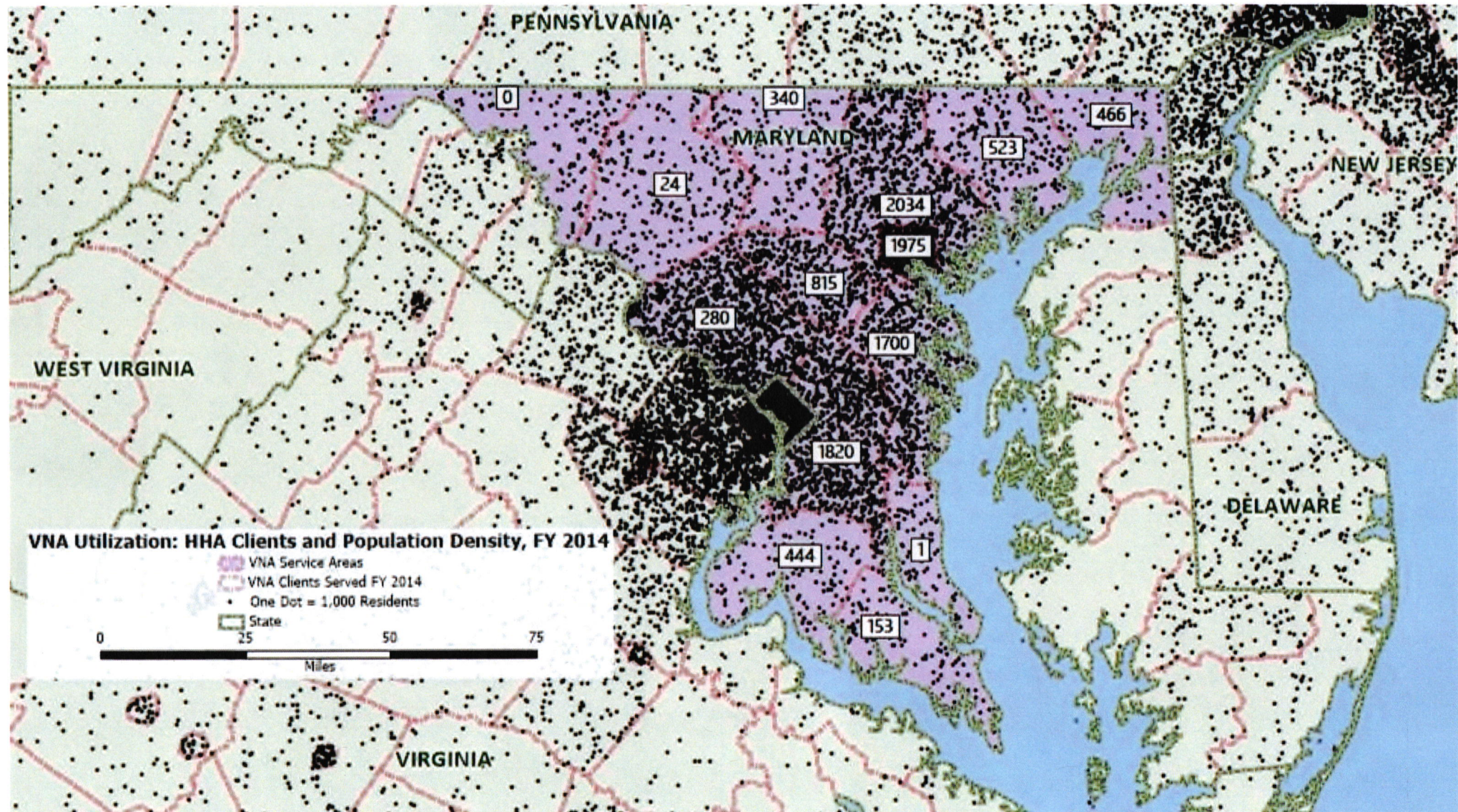
*See attached.*

Source: Maryland Health Care Commission Home Health Agency Surveys; MAPTITUDE, 2017.

## EXHIBIT 3A



## EXHIBIT 3B



## **EXHIBIT 4**

### **PHC's List of Local Resources for Collaboration**

Peninsula Home Care serves its community through advocacy and collaboration. Below is a list of local resources with which Peninsula Home Care works and collaborates to improve care, reduce hospital readmissions, reduce cost of care, and promote and sustain health and wellness in the communities it serves.

- Peninsula Regional Medical Center ("PRMC")
- Atlantic General Hospital ("AGH")
- Local physicians and care coordinators
- Patient Centered Medical Homes and Accountable Care Organizations such as the ones with PRMC, AGH, and CareFirst
- The local Area Agency on Aging – Maintaining Active Citizens ("MAC")
- Delmarva Regional Healthcare Mutual Aid Group
- Eastern Shore Area Health Education Center
- Community Foundation
- Salisbury University
- Wor-Wic Community College
- Meals on Wheels
- Wicomico County Health Department
- Worcester County Health Department
- Somerset County Health Department
- Coastal Hospice
- Health Quality Innovators
- EMS of Pocomoke & Princess Anne
- Crisfield Clinic
- Senior Centers – Berlin, Snow Hill, Pocomoke, Princess Anne, Crisfield MAC
- Local Support Groups – Diabetes, ALS, Cancer, Women Supporting Women
- Local Houses of Worship – PHC offers free classes and education on chronic disease management, medication adherence, advanced directives, blood pressure screenings
- Chamber of Commerce – All Counties

## EXHIBIT 5

### Lower Eastern Shore Population Estimates and Projections

		65+	TOTAL
	2015	37,994	211,299
	2020	43,261	220,355
	2025	49,599	231,216
CAGR	2015-2020	2.63%	0.84%
	2020-2025	2.77%	0.97%
	2015-2025	2.70%	0.90%

Source: 2017 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender (August 2017), Prepared by the Maryland Department of Planning, Projections and State Data Center.

**EXHIBIT 6**

**Insurances Accepted by PHC**

*See attached.*

AARP Medicare Complete
AETNA
AETNA MCR
American Home Patient
Apple Drugs
Auto Insurances
BCBS (MD, FEP, Out of State, excluding DE)
Bravo Health
CARECENTRIX
CAREFIRST ADMINISTRATORS
CAREFIRST FEP PLAN
CAREFIRST OF MARYLAND
CAREFIRST OUT OF AREA PLANS (MOST OF THEM)
CIGNA - THROUGH CARECENTRIX
CONIFER
CORAM INFUSION - SINGLE CASE AGREEMENTS
CVS - SINGLE CASE AGREEMENTS
EHP - THROUGH JOHNS HOPKINS HEALTH CARE CONNECTIONS
Equinox Healthcare
HEALTHSMART
HOME BASED SERVICES
HOME SOLUTIONS
HOMELINK
Humana PFFS Only (no PPO)
INFORMED
INTEGRA
JOHN HOPKINS HOME CARE CONNECTIONS
MARYLAND PHYSICIANS CARE
MOST AUTO INSURANCES
MOST WORKER'S COMPENSATION COMPANIES
MSC
PMSI- Single Case Agreement
PRIORITY PARTHERS - THROUGH JOHNS HOPKINS HOME CARE CONNECTIONS
RIVERSIDE
Secure Horizons
Today's Options
TRICARE
UHC MCR
UNINSURED EMPLOYEE FUND
UNITED HEALTH CARE MEDICARE
US FAMILY HEALTH PLAN - THROUGH JOHNS HOPKINS HEALTH CARE CONNECTIONS
VAMC